CHAPTER 11

HEALTH MANAGEMENT & OVERSIGHT

11.1. Introduction

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. World Health Organization, 1946

Maintaining optimal health is one of the most basic supports provided by DIDD and DIDD service providers. Achieving this outcome is dependent upon a number of factors including the following:

- Helping people to make person centered decisions about a healthy lifestyle and to participate, to the extent possible, in decisions about their health.
- Ensuring that people receive preventive health-related care and services, including recommended physical and dental exams.
- Ensuring that people receive assessment, treatment and follow up for acute and chronic health issues as recommended by treating practitioner(s).
- Medication management including proper administration, observation of medication effects and proper documentation as well as reporting any concerns to the proper professional(s).
- Maintaining accurate records to assure current information regarding health is available.

11.2. People are supported to have the best possible health

DIDD and DIDD providers have a shared responsibility to ensure that people maintain the best possible health. Best possible health is different for each person and depends on the individual's current overall health status and what can be done to provide preventative care, treat existing and acquired conditions or improve current health status.

11.2.a. Conceptual overview of Health Care Oversight:

It is important to note the ongoing expectation of DIDD that each person receives the level of health care oversight necessary to ensure that all his/her health care needs are met. Providers of residential, day, personal assistance, independent support coordination and clinical services are required to define in policy how they will manage and document the health care of persons served. Health management and oversight mechanisms applicable to all persons served must be incorporated into the provider's policies and procedures.

Health care oversight is an ongoing systematic monitoring and review to assure the person's health care needs are being addressed. It can be broad or limited. This includes activities such as oversight of the Medication Administration Record and medication variances. Providers are obligated to ensure that qualified staff performs appropriate health care oversight. Providers are responsible for obtaining a Professional Supports Services License from the Department of Health (DOH, reference TCA 1200-08-34) if health care supports includes the completion of tasks that can only be performed by licensed staff.

11.2.b. Health Care Management and Oversight Responsibilities of Residential, Day, Nursing and Personal Assistance Providers: Providers are expected to develop/maintain policies and implement practices that achieve the following outcomes related to health care management and oversight:

1) Appropriate consents are obtained prior to sharing health related information and prior to providing services and treatments that require informed consent;
2) Necessary medical, dental and other appointments are arranged and attended in a timely manner including routine appointments and any recommended follow-up appointments, exams or treatment;
3) Arranging and/or providing transportation for medical, dental and other appointments, timely arrival of persons supported to scheduled appointment, and preparation of the person supported for any procedure scheduled;
4) Staff accompanying persons supported to medical, dental and other appointments are familiar with the person served and are able to provide necessary information such as current medications and all physical and behavioral health issues and concerns (e.g. aggression, anxiety, etc.) to practitioners;
5) The day and residential agency's process ensures that medical providers have information about the person's current medication as well as any pertinent historical information about any allergies or issues related to specific medications.
6) Staff assist the person and/or family in requesting clarifications as needed from practitioners in regard to information provided about health-related conditions or treatments;
7) Adequate information describing the outcome of the appointment and any further recommendations is incorporated into the person's record and appropriate internal and external staff (i.e. support coordinators, case managers) are informed of recommended changes to services and/or the ISP;
8) Orders, treatments and recommendations from medical and clinical practitioners are implemented as recommended;
9) Staff monitor for and identify basic medical signs and symptoms such as swelling, rashes, shortness of breath, bleeding, etc., and report these to a medical practitioner, when appropriate (e.g., nurse, primary care provider (PCP) or emergency services);

10) Staff knows how to respond to symptoms that may indicate serious health problems requiring immediate attention and are able to take the appropriate actions (e.g., choking);
11) Staff recognizes and communicates symptoms that are uncharacteristic or abnormal for a person so the appropriate medical, clinical, dental or mental health evaluations can be initiated;
12) Medications are administered as ordered;
13) Medication administration is completed and appropriately documented by licensed and unlicensed staff;
14) Medication variances are detected, reported and addressed immediately;
15) Medication changes and other significant changes in health status are communicated to all direct support professionals who provide services to the person, to conservators/legal representatives, to family members, to support coordinators/case managers and to any other professionals who provide direct services and need the information to ensure services are appropriate and adequate;
16) Health considerations such as eating a healthy diet, participating in regular exercise and getting adequate sleep are incorporated into daily routines in accordance with the recommendations of the person's treating health care practitioners (e.g., PCP or nutritionist) and preferences as specified in the support plan;
17) Food and nourishment are provided in accordance with nutritional needs, prescribed diets, mealtime instructions and physician's orders.

11.2.c. Responsibilities of Support Coordinators and Case Managers in supporting health and oversight: Support Coordinator and Case Manager responsibilities include:

1) Information is routinely provided about services and supports available through the waiver, state plan and other community services regarding best health care choices to persons served, their families and/or legal representatives;
2) Information regarding how particular treatments and services such as physical therapy, occupational therapy, behavior services, and nutrition services may contribute to best possible health choices for the person served is routinely provided;
3) Necessary information and support is routinely provided to persons served and their family/legal representatives about addressing end of life issues.
4) Assistance with arranging and scheduling transportation to medical, dental, or other health care related appointments.

11.3. Primary Care Practitioner and Dental Services

Persons served shall have access to primary care services as needed. Regular contact with the Primary Care Provider (PCP) for physical examination, appropriate medical screenings and medical care of acute and chronic conditions is essential to maintenance of best possible health.

Persons served shall have access to dental services as needed. Regular contact with the dentist is essential to maintenance of best possible health.

11.3.a. Frequency of Physician Contacts:

Each person served must receive a medical examination according to TennCare Rules. Table 11.5 describes TennCare, CMS, and DIDD minimum requirements for medical examination by the physician.

Table 11.5
Schedule for Medical Examinations per TennCare Rule

Age	Minimum Frequency
Up to age 21	In accordance with TennCare Early Periodic Screening, Diagnosis and Treatment (ESPDT) standards.
Age 21-64	Every one (1) to three (3) years as determined and documented by the PCP.
Age 65 and older	Annually

Note: TennCare rules indicate physical exams must be annual unless otherwise noted by exception by the attending primary care practitioner.

11.3.b. Provider Responsibility for Scheduling and Keeping Physician Appointments:

- In residential services, the provider is responsible for making, and supporting the person in keeping the appointment and ensuring the outcome of the appointment is documented in the person's record.
- In day services with no residential component, the provider is responsible for working with the person, family or legal representative to make appointments, supporting the person in keeping the appointment and ensuring the outcome of the appointment is properly documented in the person's record. If the person does not obtain the medical examination as required, the provider must document, in case notes, evidence of all supports given and/or offered to the person and their family.
- If a person does not receive residential or day services, the person's Support Coordinator/Case Manager will assist the

primary caregiver as needed to ensure appointments are made, kept and proper documentation is obtained.

- The Support Coordinator/Case Manager must take every available opportunity to ensure the person attends medical examinations as needed or required (e.g. periodic medical examinations). If the person does not obtain the medical examination as required, the support coordinator/case manager must document, in case notes, evidence of all supports given and/or offered to the person and their family as well as update the person's risk assessment as to the refusal to obtain an annual examination.

11.3.c. Documentation of Primary Care Provider (PCP) and Other Physician Visits: It is not required that primary care provider's use any particular form to document the history, physical examinations and/or assessments. Documentation is required to demonstrate that an appropriate health review has been performed.

Documentation of all physician visits must be maintained. While not required, providers may wish to develop a standard form for use in assisting with the communication of all needed information. Documentation of periodic health reviews is required to demonstrate that these have been performed.

11.4. Management of Medication Administration

A statutory exemption (TCA 4-5-202 and 68-1-904) was established as a means to allow unlicensed staff to administer certain medications to people who receive DIDD services. As a result of this exemption, DOH promulgated rules which established a mechanism of training unlicensed staff to administer medications. The training curriculum, *Medication Administration for Unlicensed Personnel*, was developed by DIDD and is based on DOH rules.

11.4.a. Operating a Medication Administration Training Program for Unlicensed Personnel

Any provider agency employee who is not otherwise authorized by law to administer medications in a program for intellectual disabilities shall be allowed to perform such duties only after passing a competency test. An employee who administers medications in a program in compliance with the provision of this paragraph shall be exempt from the licensing requirement of the Nurse Practice Act and the Department of Health (DOH) Rules 1200-20-12-.03. Authority: T.C.A. 68-1-904. Before administering medications, an unlicensed employee must satisfactorily complete a medication administration training program as set forth in Department of Health Rule 1200-20-12-.02(2).

11.4.b. Utilizing Unlicensed Staff to Administer Medications: Providers who employ unlicensed staff who administer medications must be able to manage medication administration in accordance with state rules.

- Providers are required to develop, maintain and implement written policies and procedures that meet DOH requirements pertaining to the administration of medication by unlicensed staff.
- Provider policies and procedures shall be reviewed and accepted by DIDD Office of Health Services or designee prior to any unlicensed staff administering medications.

11.4.c. The Medication Administration Record (MAR): A separate MAR must be maintained for each person receiving medications. MAR required elements are specified in DOH rules (1200-20-12-.06) and are also included in the training curriculum *Medication Administration for Unlicensed Personnel*.

11.5. Provider Responsibility for Administration of Medications

Providers employing staff who administer or assist with administration of medications are responsible for the administration and management of medications during the hours services are provided.

11.5.a. Provider Responsibilities for psychotropic medications: Psychotropic medications are appropriate as part of the treatment plan for psychiatric illness. The responsibilities of providers in relation to people with prescribed psychotropic medications include, but are not limited to:

1) Documenting the response of the person supported on the psychotropic medication in terms of side effects, frequency of targeted behaviors, recipient's quality of life, and whether or not the person is taking his/her psychotropic medication as prescribed;
2) Ensuring that Tardive Dyskinesia screenings are completed by the prescribing physician or appropriately trained staff at least every six (6) months for people using psychotropic or other medications known to cause Tardive Dyskinesia;
3) Ensuring that there is a plan for "as needed" or PRN orders for psychotropic medications as ordered by the physician. The plan shall include a list of less restrictive measures to be taken or attempted to stabilize the situation should a crisis occur. Psychotropic medication may only be administered by a licensed nurse after a registered nurse or prescribing practitioner has determined that all other less restrictive measures have been taken.
4) Providing current information to clinicians regarding the medications taken by the person served, including any psychotropic medications; and
5) Ensuring training has been provided on recognizing Neuroleptic Malignant Syndrome, Serotonin Syndrome and other potentially life threatening side effects.

11.6. Managing Medication Variances

Providers who employ unlicensed and licensed staff to administer medications must manage medication variances. A medication variance occurs when a medication is given in a way that is not consistent with how it was ordered by the prescribing practitioner. Medication variances result when:

- medications are given to the wrong person,
- medications are omitted,
- medications are given at the wrong time,
- the wrong dose is given,
- the wrong medication is given,
- the medication is given by the wrong route (e.g., via injection when by mouth was ordered),
- medications are not prepared according to orders (e.g. given whole when ordered crushed or given in pill form when liquid form is ordered).

A description of medication variances and required responses to variances are provided in the *Medication Administration for Unlicensed Personnel* training.

Providers are required to implement written policies that ensure:

- reporting requirements are met,
- medication variances are identified and tracked,
- medication variance trends are identified.

11.6.a. Provider Response to Medication Variance: Providers must take prompt actions to address any medication variance that occurs, per the category of the variance. The first priority is to determine how the medication variance has affected, or could affect, the person and ensure measures are taken to stabilize or prevent deterioration of health status. If the potential for harm is present, the person's prescribing primary care practitioner, pharmacist or a hospital emergency room should be contacted for consultation. Actions expected to occur following stabilization of the person's health status include, but are not limited to:

1) Contacting the health care practitioner who prescribed the medication.
2) Documenting the variance in the record.
3) Documenting instructions received from the prescribing practitioner consulted and follow up actions taken by staff member.

Medication variance categories include Categories A - I. Categories D and above require primary care practitioner contact. See Medication Variance Form MR-0484 for further information.

11.6.b. Documenting and Reporting the Medication Variance: The provider is responsible for documenting medication variances in the person's record. The documentation should report what medication was given, what medication should have been given, and any intervention that resulted. The Medication Administration Record (MAR) should indicate the nature of the variance. For example, if the dose was administered incorrectly or omitted; if the wrong medication was administered; if medication was given by the wrong route and/or if medication was not prepared according to orders (e.g. given whole when ordered crushed or given in pill form when liquid is ordered). When any variance occurs, a DIDD approved medication variance form should also be completed. Not all medication variances are reportable incidents. Reportable incidents are defined in **Chapter 18 of this manual.**

11.7. Response to Medical Emergencies

All persons will have some form of identification that includes emergency contact information. Direct support staff should be trained to recognize symptoms indicative of medical emergency such as excessive bleeding, choking, loss of consciousness, expression of significant pain, obvious bone fracture, obvious break in skin integrity, etc. Staff should also be able to recognize any symptoms specific to the person that indicate he or she is feeling sick or becoming ill, based on known medical conditions or past experiences. All staff should be able to provide emergency personnel with accurate and detailed information regarding the incident or circumstances which preceded the person's current medical condition, such as diagnosed medical conditions, allergies and current medications. Staff should be knowledgeable about advance medical directives for the person. Note that 'Do Not Resuscitate' orders do not apply to choking. The names of the physicians treating the person should be presented to emergency personnel as well.

Written policies and procedures and training that communicate to direct care staff actions expected to be taken in a medical emergency should include at a minimum:

- Instructions that 911 calls must not be delayed;
- Information regarding initiation of emergency first aid procedures;
- Instructions on how to help someone who is or appears to be choking;
- Requirements for provision of information to emergency medical personnel;
- Requirements for notification of designated provider supervisory staff; and
- Making information accessible in a timely manner.

11.8. Provision of Basic First Aid

Staff is to administer basic first aid. See Chapter 7 for specific training requirements.

11.8.a. First Aid Supplies/Kits: Stocked first aid kits must be accessible in residential settings and in any other site where services are routinely provided such as a home, day service site and vehicles used for transportation. First aid supplies will be kept in a secure container which includes items recommended by the American Red Cross. The contents of first aid kits shall be accordance with the current Red Cross recommendations.

11.9. Ensuring Continuity of Care During Hospitalization and Upon Discharge

11.9.a. Primary Provider Responsibilities: When in-patient hospitalization is necessary, communication, planning, collaboration and coordination between DIDD, provider staff and hospital staff is essential to continuity of care. Primary provider responsibilities include:

1) Ensuring a contact list is provided to hospital staff describing individuals to be called regarding medical issues and the circumstances under which such calls are to be made;
2) Ensuring that required items are taken to the hospital with the person, including personal items, medical information and copies of other relevant information including but not limited to a list of current medications and dosages;
3) Ensuring appropriate individuals are contacted, including family members, legal representatives, the support coordinator/case manager, medical providers and other DIDD providers.

11.9.b. Support Coordination/Case Management Responsibilities:

Be aware of changes to health status or needs of person in regards to long-term supports which may result from the hospitalization. If such changes occur, update the ISP within 14 calendar days from date of discharge to ensure the person's needs continue to be met.

1) Provide the hospital with contact numbers for the support coordinator/case manager, as well as information regarding how to make contact after hours.
2) Provide communication links between the person, family, legal representative, service provider and hospital staff.

3) Make hospital discharge planning staff aware of the role and assistance that the support coordinator/case manager is able to offer in identifying and obtaining the supports and services available to the person upon discharge.

11.9.c. Discharge Planning: Discharge planning should begin as soon as a person is admitted to an inpatient hospital. The support coordinator/case manager will collaborate with the family and/or the residential provider to ensure the person has adequate supports while receiving in-patient hospital care. The support coordinator/case manager will also coordinate any amendments to the ISP to include any anticipated additional services that may be needed post-discharge. Discharge planning activities performed by the ISC should include:

1) Where the person is to go following discharge;
2) Identification of individuals and/or medical professionals to be contacted and informed when discharge is imminent;
3) Arrangements to resume or change previous professional services as appropriate and/or arrangements for providers of any new services and supports needed post-discharge;
4) Arrangements for any environmental modifications or new equipment needed post discharge;
5) Arrangements for transportation to alternative treatment facilities if necessary;
6) Providing instruction and/or training to new staff as needed to support the person served post-discharge;
7) Ensuring an adequate supply of medication needed in accordance with physician's orders post discharge; and
8) Making arrangements for follow-up appointments.